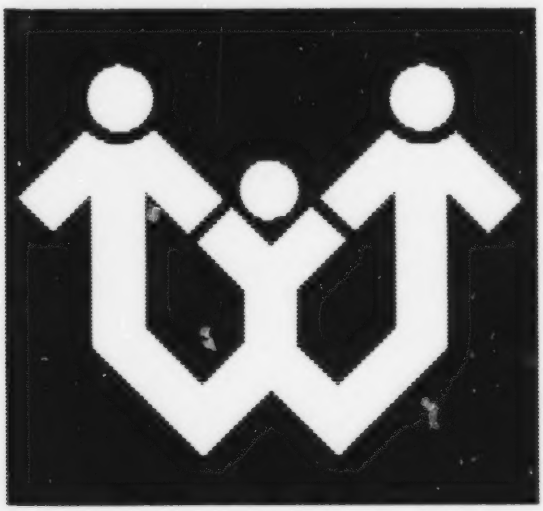
# Community Behavioral Services

## A 10-year Progress Report

## 1975 - 1985



Alberta
SOCIAL SERVICES
Edmonton Region

87-00974/

**Some comments:**

...*"should be available to* ***all*** *parents."*
**— parent.**

...*"very high degree of proficiency and professionalism."*
**— vocational operator.**

...*"terrific service, keep up the good work."*
**— teacher.**

...*"genuine concern and support."*
**— employer.**

...*"well organized, easy to approach and available when needed".*
**— group home staff.**

...*"a model program, overall exemplary."*
**— professional reviewer.**

# COMMUNITY BEHAVIORAL SERVICES

## A 10-Year Progress Report

## 1975 - 1985

09/86

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## PRELUDE

In 1973, the Alberta Government established the Branch of Services for the Handicapped with a responsiblility for ensuring the availability of community services for persons with mental handicaps.

In that same year, a group of concerned parents and Branch employees in Edmonton began discussing the need for services for individuals with mental handicaps who also displayed behavior problems which (1) prevented their admission to existing programs or (2) were considered unmanageable at home. Previously, such individuals were often referred to a provincial institution; little support was available to parents who chose to keep their children at home and in the community.

By 1974, a program proposal was developed to provide family support and residential accommodation for children with behavior problems. This program, called Behavior Management Services, began in 1975.

Much has happened with this Service during the 10-year period between 1975 and 1985. This report summarizes some of these activities in the hope that the information will be useful to others who plan or operate similar services.

### A Note on Terminology:

The staff at C.B.S. are aware that the words we use to denote people and ideas can have an impact on the way those people and ideas are perceived and treated by others. Thus, a conscious effort is made to use

terminology which provides positive-valued images. Although this change in language is sometimes cumbersome and does not always occur in practice, we endeavor throughout this report to ensure: that clients are more appropriately referred to as individuals, persons, children or adults; that "mentally handicapped persons" are persons first, and secondarily with mental handicaps; that "behavior management" is replaced with the broader term, behavioral instruction; and that "parent training" is more suitably called parent instruction or education. A very sage advocate for persons with mental handicaps recently remarked at a local conference, ... "dogs are trained, parents are instructed"!

In 1980, we even changed our name from Behavior Management Services (B.M.S.) to Community Behavioral Services (C.B.S.), partly because of the negative connotation of the words "behavior management" (which conjures up images of manipulation and problem behaviors) and partly to reflect our involvement in more than just the technical management of problem behaviors. The need for counselling and instruction in independent living skills became evident early in the provision of this service.

We sincerely hope that this positive imagery doesn't detract from the essence of this report.

Larry MacDonald, Ph.D.

Director, C.B.S.

# HISTORY

The original proposal for a behavioral service, in 1974, called for two separate but inter-related components to be developed in the Edmonton Region: (1) A Behavior Management Training Centre with 10 spaces for children with more severe behavior problems, and (2) an Outreach Unit of 10 Counsellors to provide parental and agency instruction and consultation. Also proposed for later development were several residential "clinics", each with five spaces for children with less serious behavior problems. This "system" was considered adequate to meet the needs of the estimated 800 persons with mental handicaps in the Region who displayed behavior problems. Such problems ranged from simple nuisance behaviors to more severe behaviors like aggression and destruction of property.

In those early days, the Edmonton Region consisted of the northeast half of Alberta from Wetaskiwin to the Northwest Territories, an area of 120,000 square kilometres with a population of 825,000, over half of which lived in and around the city of Edmonton.

In April, 1975, 18 staff were hired and began an intensive four month orientation and training program. By September, staff were ready and eager to provide services. Unfortunately, the Centre was not yet ready for occupancy. Renovations to an old duplex were more extensive than anticipated, thus requiring all staff to be temporarily involved with the Outreach program.

Outreach

A flourish of activity resulted in the first draft of a parent-instruction package (see reference #1). Teams of four staff taught groups of 8 to 12 parents in a workshop format with weekly home visits. The results were encouraging. Parent satisfaction scales completed at the end of the workshops showed that parents were able to change their children's behaviors and the majority of parents (75%) were satisfied with the extent to which they were able to do so.

However, it was also obvious that some parents were not benefiting from the workshop. About 25% were either dropping out or were unsuccessful at applying the procedures in the home. Reasons for dropping out included language difficulties, travelling distances, inclement weather, lack of babysitters, etc. Thus began an alternative model of parent-instruction -- home consultation. Instead of attending the group workshop, parents received one-on-one consultation from a behavioral counsellor in the home. Rather than teaching more general behavioral procedures, the focus with these parents was to assist them as necessary in designing a program which suited their needs and abilities. Both formats - group and home consultation - were continued over the years with only slight modifications. Almost all parents were successful with one of these two formats.

In 1981, an "intensive" home-consultation format was initiated to increase

the success rate with families who required additional modelling of the procedures. In effect, a counsellor not only assisted with the design of a behavioral program, but actually demonstrated the program in the home, sometimes daily for several days per week.

On occasion, one of these three formats still did not meet the needs of a family. In those cases, it was generally because of other problems within the family (eg. marital discord, maternal depression, etc.) which prevented parents from carrying out the behavior-change programs. This problem was addressed in 1982 with the establishment of the Social Services Team.

Social Services Team

A Social Worker and Psychologist were hired to assess referrals and counsel those families whom they felt would not benefit from a parenting program. The effectiveness of these interventions is being evaluated at the time of this report. Early indications are that preliminary counselling of parents increases their willingness and effectiveness in carrying out behavior-change programs.

In 1983, as the need for parent-to-parent support became more evident, the Social Services Team established a Parent Support Group for parents of children with mental handicaps. An Adolescent Support Group was established in 1985 for teens with an obvious need to improve their social skills and learn anger control. Both the parent and adolescent groups were well attended and going strong at the time of this writing.

Residential

By April, 1976, the "Behavior Management Training Centre" began to accept children with mental handicaps who displayed behavior problems. A renovated duplex, with five bedrooms, was used to provide short-term residential accommodation for the assessment and training of five children. A sixth space was available to children for periods up to 30 days in order to provide relief to parents.

Within the Centre, a team of nine Counsellors (Rehabilitation Practitioner I's) were involved in the design and implementation of individual learning programs, based on an assessment of each youngster's behavioral excesses, deficits, and assets. During the day, all children attended a school program in the basement of the C.B.S. Administration building (next to the Centre). Whenever possible, parents enrolled in the Outreach workshops so that re-integration of children into the natural home environment was likely to be successful. In addition, parents were expected to remain involved with their children by visiting the Centre at least once a week to help develop and carry out the behavior-change programs under staff guidance.

On average, children stayed in the Centre six to eight months before returning home. Follow-up services by Outreach staff continued for at least three months, and longer if necessary, to ensure parents were capable of maintaining and teaching appropriate behaviors.

Those children who did not return to their natural parents for a variety of reasons, were sometimes placed with a family through the Family Home Program. Operated by the Alberta Government, this program consisted of approximately 12 family settings where surrogate parents were paid to care for up to three children with mental handicaps. Unfortunately, access to this program and the foster-care system was frequently unavailable to children from the C.B.S. Centre because they were labelled "behavior problems". Social Workers arranging placement with these families, often argued that a particular child, although he behaved appropriately in the Centre with strict guidelines and a large staffing component, would probably not behave similarly in a family-type setting.

Specialized Family Home

To counteract this argument, a "half-way house" called the Specialized Family Home was established in the fall of 1978. This 3-bedroom home was used as a "stepping-stone" to the community; that is, the structured behavioral programs established in the Centre were to be gradually phasedout within a family-like environment, thus providing children with an opportunity to prove that they could function in a less-restrictive setting. The home was permanently staffed by a couple who were provided with consultation support through the Outreach Program.

Many positive changes were made over the six years that the Specialized Family Home was in operation. Higher qualifications of "parents" were

required, an In-Home Specialist position was created to provide more support, admission criteria were strengthened to ensure post placement was available, parents were given more responsibility and independence in the operation of the home, and benefits and salaries were increased substantially.

In spite of these changes it was difficult to maintain a continuous operation from year to year. While nine children made use of the home, four different couples came and went. It became increasingly obvious that the job of parenting three children with behavior problems was not an easy one, even with the support of the In-Home Specialist. It was both technically demanding and emotionally draining. Several times, when parents terminated, children had to be returned to the Centre which, itself, was usually operating at full capacity. After six years of never quite meeting expectations, the Specialized Family Home was closed.

# TRANSITIONS

In 10 years of service delivery, many changes have been made as a result of consumer needs, program evaluations, parent and staff suggestions, and departmental objectives. This section attempts to briefly describe the major developments within individual units between 1975 and 1985.

Outreach

Generally viewed as the least-intrusive method of service delivery, the Outreach Program offers behavioral services to families and agencies involved with persons who have mental handicaps and behavior problems.

Parent workshops are conducted several times during the year. Lead by two behavioral counsellors, each workshop runs in the evenings for a couple of hours each week for six weeks. Parents are taught how to design behavior-change programs, how to implement their programs, and how to maintain the behavior-changes accomplished through these interventions. Counsellors make a weekly visit to the home to ensure parents understand the material presented in the workshops and that they are completing their assignments. Follow-up services are provided for at least three months or as long as necessary, depending on the needs of the parents.

Home and agency consultation are available to any family unable to attend the workshops or to any agency serving people with mental handicaps.

Consultation to these families and agencies (day-cares, schools, pre-vocational and vocational services, group homes, extended care) consists of weekly meetings by a Behavioral Counsellor with parents or agency staff. The Counsellor assists parents and agency staff in identifying behavior problems, developing and implementing behavior-change programs, and monitoring the programs for effectiveness. Follow-up services are then provided for at least three months or as long as necessary.

The goal of the Outreach Program is to provide a behavioral service that will have long-lasting results for persons with mental handicaps and those families and agencies involved. Several developments have occurred over the years to increase the effectiveness of this program:

1) Workshops have been fine-tuned to include the use of video-training, role-playing, modelling, increased parent participation, supplementary instruction packages and booster sessions. These changes were made to the workshop format when follow-up research indicated that parents were able to change their target behaviors during and after the workshop, but they were not very successful at applying the procedures to <u>new</u> behaviors (see reference #2).

2) Consultation typically is provided on a weekly basis but in the event of limited program success or regression, intensive consultation can be provided. The Behavioral Counsellor determines the degree of

consultation required to effect some improvement and may choose to spend two or three days per week working directly with a mediator and the referred individual to achieve that improvement.

3) An Edmonton region rural-based Behavioral Counsellor began work in the district office in Edson, Alberta in 1982. With Behavioral Counsellors in Edmonton being most effective working within a 50-mile radius of the city and the demand for outreach services increasing, the establishment of the Edson-based position alleviated the pressure to provide service to the entire region from the C.B.S. offices in Edmonton. (In 1980, the Edmonton region was reduced to about 40,000 square kilometers when reorganization of the Department resulted in the establishment of a separate Northeast region).

4. An Integrator position, later called the Residential Community Counsellor (R.C.C.), was established in 1978 to coordinate services between C.B.S. Outreach and Residential Programs. The R.C.C. was responsible for ensuring that the post-placement home or agency was prepared to maintain the behavior-changes accomplished by the Residential Program and to establish some program stability in the post-placement before assigning the case to another Outreach staff who would complete the follow-up.

Numerous changes have taken place specific to this R.C.C. position in the past few years: a formal pre-placement assessment by the R.C.C.

provides residential program staff with information about a referral before he/she is admitted; a parent-instruction format has been designed specific to the needs of parents of children receiving residential services; and a pre-integration assessment was devised to measure the "readiness" of the parent or agency to receive an individual from a C.B.S. residence. These developments have improved the coordination and consistency between the residential and post-placement environments.

The number of outreach staff has varied over the years. In 1975, only four positions were allotted to do parent-instruction and consultation. As the demand for service increased during the next few years, the number of positions rose to 12. However, with the demand for outreach positions increasing in the Northeast and Northwest regions of the province, C.B.S. offered three positions to these regions. Currently there are nine outreach positions (a Unit Supervisor with seven Behavioral Counsellors in Edmonton and one in Edson). Indications are that C.B.S. is able to meet the demand for service in the Edmonton region with limited waiting time.

The waiting list for consultation and parent workshops is usually less than 12 and services can generally be provided within six weeks of the referral date. Each Behavioral Counsellor, with the exception of the Unit Supervisor, has a standard caseload of 12 persons, each requiring a weekly visit to their home and/or day program throughout consultation. In addition, each counsellor is expected to conduct at least one parent workshop per year.

In the 10 years encompassed by this report, the Outreach Program provided 40 workshops to a total of 326 parents and 463 home and agency consultations (see Table 1). From a sample (n=67) of individuals served, it was determined that the rate of success is approximately 90%. That is,

TABLE 1

Service Provided by Outreach Program

| | Parent Workshops | Home/Agency Consults** |
|---|---|---|
| 1975-76 | 66 | 3 |
| 76-77 | 39 | 5 |
| 77-78 | 39 | 30 |
| 78-79 | 29 | 35 |
| 79-80 | 13 | 47 |
| 80-81 | 14 | 66 |
| 81-82 | 18 | 83 |
| 82-83 | 24 | 69 |
| 83-84 | 28 | 68 |
| 84-85 | 56 | 57 |
| TOTAL | 326 | 463 |

** The number of individuals served on Home/Agency consults averages three per consultation; thus, the total number of individuals directly served through consultation is approximately 1400 over the 10 year period.

9 out of 10 parents were able to modify the behaviors of their children through participation in either the parent workshop of home consultation (see page 37 for more information on this survey). A study is currently underway analyzing data from a larger sample of individuals served by the Outreach Program over the past 10 years in an attempt to validate this finding.

Social Services Team

The Social Services Team was developed in 1982 to provide counselling and support services to families with problems that interfered with the successful behavioral instruction of a child. Our earlier experiences with families supported research showing that the best developed behavioral programs would not work if the persons trying to implement them were preoccupied with other problems.

Although an Intake Worker had been employed by C.B.S. since 1975, the position primarily involved the processing of referrals and coordination of services, leaving no time for provision of counselling or other support services. To rectify this, a Social Worker position and a half-time Psychologist position were created and a service process developed for determining a family's needs.

When a referral is made to C.B.S., the Intake Worker interviews the family to gather relevant information. To identify those families not likely to benefit from the parent workshop or home consultation, the Intake Worker asks parents to complete a Parental Stress Index. This standardized assessment tool is used to identify parent-child systems under stress and in need of professional intervention. As well, the Intake Worker completes a "Probability of Success" Scale (developed by the Social Services Team) on each family which identifies 15 factors known to interfere with the successful completion of workshops or home consultation.

Based on the results of these scales and the Intake Worker's observations, the Psychologist or Social Worker may complete a more thorough family assessment to determine if outreach services are most appropriate for a family or if other interventions are indicated. If counselling is required, the intent is to provide specific recommendations to change problem situations in order to enhance family communication, interaction, and participation in the Outreach Program. Following counselling, parents are asked to again complete the Parental Stress Index to evaluate the effectiveness of the counselling. If long-term counselling is indicated, the family usually is referred to more appropriate services outside of the agency; otherwise, parents are encouraged to attend the workshops or receive home consultation. This formal evaluation was only recently implemented at C.B.S. so results are not yet available on its overall effectiveness.

A Parent Support Group and Adolescent Group are also coordinated through the Social Services Team. The Parent Support Group meets monthly in an informal atmosphere where parents can discuss mutual concerns or invite guest speakers to present relevant information. The Adolescent Group provides training in social skills, relaxation and anger control to teens with a mild mental handicap. Meeting are held bi-monthly and outings are planned frequently to enable the teens to practice skills learned in group sessions.

The Social Services Team is also responsible for providing information and assistance with referrals to families who need outside agency help.

Residential

In 1984, the Specialized Family Home closed its doors and the Government began to implement fiscal restraint measures and encourage innovative ideas to "do more with less". After a thorough review of program and budget issues, the management team at C.B.S. decided to close the 6-bed Centre, relocate to a 3-bed residence and use the Specialized Family Home facility for a second 3-bed residence. Both had two permanent beds and one relief bed. The smaller residential units, in comparison to the 6-bed Centre, provided more individualized attention to each child, more consistency in programming, less negative modelling, and a more normalized environment which significantly reduced re-integration difficulties when a child returned home.

Our experience with the Specialized Family Home suggested that a permanent live-in Operator, supported by sufficient staff, would provide the necessary consistency in programming while at the same time minimize "burnout" of the Operator. This contracted Operator, supported by four Counsellors (RP I's) in each home, participated as a team member and was also responsible for household maintenance.

In the past two years, several individuals and couples have come and gone as Operators in each of the homes. It is difficult to find someone who is willing to remain at the job for an extended period of time. In some cases, operators who moved from the city or took other jobs reported that

they had been "happy" with the job; in other cases, they reported they couldn't tolerate the stress associated with continous exposure to children with severe behavior problems and left with a career change in mind.

We are now of the opinion that the nature of this work is not conducive to maintaining a normal family life and specifically advertise for individuals, as opposed to couples. to assume the role of Operator. In most cases, individuals usually do not object to the disruption and unavoidable invasion of privacy by staff participating in the program.

In 1985, continued fiscal restraint and the Department's emphasis on "downsizing" resulted in a decrease of five positions at C.B.S., requiring the closure of one of the children's residences. At the time of this report, C.B.S. provides two "permanent" spaces and one relief space to serve Edmonton and the two Northern regions. Considering that the waiting list for the Residential Program averaged five to six children, a change was made to the service process. Instead of serving children until they meet pre-determined behavior-change criteria, a child now stays for a maximum of 12 weeks, during which time both the child and the parents receive instruction to maximize the likelihood of success in the post-placement home. It is still too early to report on the success of this model but preliminary indications are promising.

In the past nine years, the Residential Program has provided training to 53 children and provided relief for parents to 670 children (see Table 2).

TABLE 2

Children Served in Residential Program

| | Permament Beds | Relief Bed | Weekend Beds** |
|---|---|---|---|
| 1976-77 | 10 | 17 | 0 |
| 77-78 | 8 | 25 | 32 |
| 78-79 | 5 | 25 | 44 |
| 79-80 | 4 | 35 | 38 |
| 80-81 | 5 | 47 | 30 |
| 81-82 | 4 | 47 | 46 |
| 82-83 | 9 | 67 | 36 |
| 83-84 | 4 | 64 | 38 |
| 84-85 | 4 | 69 | 10 |
| TOTAL | 53 | 396 | 274 |

** When children went home on some weekends, these beds were used by other children as weekend relief for parents.

Adult Assessment Unit

During the first three years of C.B.S. operation (1975 to 1978), the emphasis had been on serving children. In 1979, three additional outreach positions (bringing the total to seven) were created to serve adults. In 1981, a short-term residential program was opened for adults with "mild to moderate" behavior problems. Since the initial focus of this program was to conduct thorough assessments of adults to determine their suitability for various community placements, the facility was called the Adult Assessment Unit.**

** In 1980, a Departmental re-organization resulted in a reduction in the size of the original Edmonton region and the establishment of Northeast and Northwest regions in Alberta. Because of the lack of residential accommodation in these two northern regions for individuals with behavior problems, the C.B.S. Children's Residence and the Adult Assessment Unit served referrals from these regions on an equal priority basis with individuals from the Edmonton region.

By 1982, the focus had shifted from assessment to intervention when it became apparent that behavior problems often prevented placement in most community facilities. The staffing model included five R.P. I's, an R.P. II (team leader), a housekeeper and a night staff. Staffing ratios were two staff to three residents which allowed for some one-to-one sessions. Only during sleeping hours was one staff ever alone with three residents.

The service format included a six-week assessment, using a formalized battery of assessment tools, followed by an intensive short-term instructional program which focused on decreasing inappropriate behaviors. Adults usually remained at the Unit for an average of four months (range: 1 to 25 months) with a three month follow-up period provided by Outreach to the post-placement residence. In the four-year period between 1981 and 1985, 21 individuals made use of this facility (see Table 3).

TABLE 3

Adults Served in the Adult Assessment Unit

| | Permanent Beds |
|---|---|
| 1981-82 (5 months) | 4 |
| 82-83 | 9 |
| 83-84 | 4 |
| 84-85 | 4 |
| TOTAL | 21 |

In 1984, partially as a fiscal restraint measure and partially to increase consistency in programming and improve the normalization aspects of the

Unit, the A.A.U. converted to an operator model similar to that established in the children's residence. Essentially the night staff and housekeeper were replaced with a contracted live-in Operator who also assisted in the implementation of instructive programs. Evaluation of this model is currently underway.

A major concern, which has emerged in the past year, is the unavailability of post-placement residences, resulting in a lack of movement from the Unit. Although admissions required a post-placement, such placements were not always available when the individuals were ready for discharge. This situation was not only detrimental to the residents who should have been moving to less restrictive settings, but prevented other individuals from accessing these spaces. On average, five to six persons were on the waiting list at any given time. Alternative placements involving individualized funding are currently being considered for adults ready for discharge from the Adult Assessment Unit.

# FEATURES OF C. B. S.

This section describes various features of C.B.S. as they relate to the operations of the aforementioned programs.

Philosophy

The basic philosophy of C.B.S. is that all persons, regardless of age or the severity of their disability, are capable of learning behaviors which will allow them to become more useful members of society. External observable behavior, rather than some ill-defined internal state, is the primary focus in implementing change. Behavioral techniques and adherence to principles of normalization are the modus operandi of C.B.S.

Although a major concern of the service is a reduction or elimination of inappropriate behaviors, the value of preventing these inappropriate behaviors from occurring in the first place is recognized. This preventive approach is one rationale for teaching general principles of behavioral instruction to parents. Not only can these principles be used to eliminate other inappropriate behaviors but they can also be used to prevent the onset of inappropriate behaviors - - an approach requiring less time, effort and adverse effects. In this regard, parents and agencies are requested to make their referrals as early as possible in the evolution of a behavioral problem. Oftentimes, the problem can be prevented from reaching crisis proportions by such preventive measures.

Keeping in mind the potential for misuse of behavioral techniques, an

important aspect of the service is concern for each person's human dignity and rights, including the right to a program plan which will assist him or her to function more effectively. This concern is reflected in two developments: (1) the parents or guardians, and where possible, the individuals, participate in the design and implementation of all behavioral programs and have full authority to terminate any program at any time; (2) an independent Advisory Board is available to monitor all aspects of the service to ensure that humane programs are implemented which will be most productive for eventual re-integration of individuals back into the community.

Admission Criteria

The Outreach Program serves both children and adults who are diagnosed as mentally handicapped and are defined by either their parents or community agencies as having behavioral or developmental problems. The majority of these persons live with their parents at home or in group home settings while attending school or vocational programs in the community.

Admission to the children's residence is restricted to children between the ages of 3 and 17, who are ambulatory, and for whom a school program and post-placement is available.

The Adult Assessment Unit accepts any adult with a mental handicap, having "mild" or "moderate" behavior problems. Individuals exhibiting violent or destructive behavior are not considered. The adult must be 18 years of

age or older, ambulatory, attending a day program, and have a confirmed post-placement.

Priority Scale

A priority scale has been developed to assess persons according to their need for service. This scale takes into consideration the extent to which the home or day placement is in jeopardy, the general attitude of parents or agency staff toward the individual and their willingness to be involved in programming, as well as whether or not a day placement is secured and a residential post-placement identified. Use of the scale allows an objective decision to be made as to which referrals are most in need of service.

Service Agreement

At the time of admission for service, C.B.S. and the parents, guardians, or community agency enter into a service agreement which outlines the terms of service, including the responsibilities and expectations of both parties. Parents, guardians, or agency staff are informed of the general approach to be used in the intervention, the nature of the service (outreach or residential), and the appeal route to be used in the event that they are dissatisfied with the service. C.B.S. agrees to provide the appropriate service and the parents, guardians, or agency staff agree to participate in the particulars of the service, such as attending the workshops, carrying out behavior-change programs, and adhering to the rules and regulations of the residential programs.

Advisory Board

An independent board has been established to help ensure that procedures and programs are established which are maximally effective, and yet, do not infringe on the human and legal rights of the persons served. Board members, 16 in number, represent a wide variety of agencies directly involved in protecting the interests of persons with mental handicaps. Their function is to advise and recommend on all aspects of service, from referrals and placement, to procedural and programming considerations. This board provides one means of achieving an effective working relationship with concerned citizens in the community. Current members and their affiliations are as follows:**

| | |
|---|---|
| Dr. David Baine | U of A, Educational Psychology |
| Dr. Don Cameron, Chair | Advocacy |
| Ms. Melanie Cheek-Yadlowski | St. Albert Assoc. for the Handicapped |
| Dr. Dennis Ewanyk | Solicitor General's Department |
| Dr. Ehor Gauk | Alberta Medical Association |
| Rev. Ray Glen | Clergy |
| Mr. David Haas | Legal |
| Dr. Larry MacDonald, Secretary | Community Behavioral Services |
| Dr. Stew McDonald | Grant MacEwan Community College |
| Ms. Gloria Mohr | Public Health Services |
| Mrs. Fran Prosky | Robin Hood Assoc. for the Mentally Handicapped |
| Dr. Jean Ruth, Vice-Chair | Edmonton Public School Board |
| Mr. Bob Steele | Edmonton Separate School Board |
| Mrs. Joan Torguson | Community Representative, Inglewood |
| Mr. Bruce Walker | Mental Health Services |
| Mrs. Louise Walley | Edmonton Assoc. for the Mentally Handicapped |
| Ms. Iris Zapach | Gateway Assoc. for the Mentally Handicapped |

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** The Director and staff of C.B.S. wish to express their appreciation to the many individuals who have volunteered their time and effort to serve on this board over the last 10 years.

Route of Appeal

The staff at C.B.S. feel it is very important that persons receiving service can freely and openly discuss concerns they may have during their involvement with the agency. These concerns may range from the appropriateness of a person's individualized program to dissatisfaction concerning policies and procedures of C.B.S. Usually, such concerns can be resolved through discussion with the Program Manager, but in the event that they cannot, an appeal route is available which progresses from the Director of C.B.S., to the Manager of Community Rehabilitation Programs in the Edmonton region, to the Advisory Board and finally to the Minister of the Department of Social Services. Fortunately, the appeal route has not had to be used during the 10 years encompassed by this report.

Parent/Agency Satisfaction Scale

In order to continually assess the quality of programs at C.B.S., each parent or agency staff is asked to anonymously complete a Satisfaction Scale after receiving service. This questionnaire allows consumers to voice their level of satisfaction with the facility, parent workshops, consultation, counsellors' attitudes, program techniques, their success at behavior change and whether or not they would recommend C.B.S. to others.

The information from these scales is used to alert staff to program deficiencies, thereby allowing for improvement in the quality of service provided.

## In-Service Training

Regular in-service training sessions are held to ensure that C.B.S. staff are exposed to the latest therapeutic procedures. Training may consist of a review of some specific procedure, a tour of a relevant facility, a film, discussion of specific programming problems, or review of an individual's program. In addition to the training benefits, these in-services seem to increase staff morale and provide opportunities for identifying strengths and weaknesses in both the outreach and residential programs.

## Job Skill Evaluation

Behavioral instruction skills of C.B.S. staff are evaluated by formal examination once a year. This exam involves a practicum where the staff implement a behavioral program or complete a written exam that may include definitions, multiple choice, or long-answer questions. The results serve to identify a staff-person's weaknesses in areas of behavioral programming; they are not used in any way to support the government's required annual staff performance ratings.

With the areas of weakness identified, staff are provided with appropriate in-service training, reading material, or direct on-the-job training. Staff at C.B.S. appreciate the need for attaining and maintaining a high level of competency in the principles and application of behavioral techniques.

A validated certificate is issued to each C.B.S. staff person upon termination of service. This certificate indicates the various program areas in which the staff person has worked and reflects the fact that skill evaluations were successfully completed.

Job Satisfaction Survey

Once a year, staff are requested to fill out a job satisfaction survey form. This survey is intended to identify levels of job satisfaction in seven major areas: general job characteristics, specific job characteristics, supervision, administration, orientation training, ongoing training, and support resources. The results of the survey, which include staff recommendations, are used to improve areas in which there is expressed dissatisfaction with the job (see reference #3).

Staff Rotation

After working at C.B.S. for at least six months and annually thereafter, staff may request a rotation to another relevant agency within Edmonton for a period of one to three days. This rotation affords staff an opportunity to learn about other agencies and to receive first-hand experience in dealing with different populations of people with handicaps, often providing them with new strategies and ideas which they can apply in their present positions.

Role Exchange

Within C.B.S., staff are given the opportunity to spend a half day "shadowing" another employee of the agency. The purpose of this exercise is to share information about job responsibilities with other staff. Part of the time is spent in reviewing these responsibilities and the remainder spent in actually going through the activities of the job. Staff generally come away from these exchanges with a better understanding of how the person they shadowed "fits" within the functional organization of the agency.

# EVALUATIONS/ACCOMPLISHMENTS

An evaluative strategy has always been employed at C.B.S. in the improvement of its service delivery. This is evident in both individual program evaluation and overall system evaluation.

In 1976, a PASS evaluation was conducted to assess the quality of C.B.S. in terms of it's adherence to normalization practices. At that time C.B.S. met acceptable standards, even without extensive opportunity to implement normalized practices.

In 1978, a comprehensive program evaluation was conducted by Dr. Tymchuk from UCLA, who described C.B.S. as "a model program ... overall exemplary".

In 1980, another PASS evaluation was conducted by a team from the National Institute of Mental Retardation, and again, the feedback was positive in terms of C.B.S. adherence to normalization practices.

In 1982, evaluators from the University of Calgary assessed a residential component of C.B.S., the Adult Assessment Unit, which had been operational for only a year. In general, feedback from this evaluation indicated that the program was of high calibre and much in need within the Edmonton community.

In 1985, an external evaluation was conducted on another component of

C.B.S. — the Social Services Team. Evaluators from the Mental Health Division of Social Services found the team to be a necessary and useful adjunct to the behavioral programs in effect at C.B.S.

In 1985, another comprehensive evaluation was conducted by Dr. Tymchuk from UCLA to determine whether goals and objectives were being met and whether recommendations from the 1978 review were being followed. While some recommendations suggested minor changes in service delivery, the overall report was positive and consistent with the 1978 evaluation. As well in 1985, a survey of agencies was conducted to evaluate their satisfaction with the services provided by C.B.S. The results clearly indicated overwhelming support for and satisfaction with these services.

In addition to these major evaluations, C.B.S. has mechanisms in place to ensure feedback is obtained from both consumers and staff about their services. All families and agencies who participate are asked to provide evaluative feedback regarding the services they received. C.B.S. staff are asked periodically, to provide feedback regarding satisfaction with various components of their jobs. Incidentially, our research has shown that such feedback is more valid and useful when the job satisfaction forms are completed anonymously (see reference #4). Annual problem-solving workshops are held with full staff participation. Also, individual program audits are conducted annually by outside professionals in both outreach and residential programs.

Although service delivery is the major focus of C.B.S. programs, evaluative research has been conducted in a variety of areas resulting in numerous publications and conference presentations on behalf of C.B.S. and the Department of Social Services. For example, C.B.S. has developed an ethical decision-making model which is used to guide staff in making decisions about whether to apply a positive or negative program for each individual at various points in the intervention (see reference #5). On occasion, an innovative technique has been used at C.B.S. to successfully modify an individual's maladaptive behaviors (see reference #6). Also, a Maladaptive Behavior Scale has been developed which allows individuals to be assessed as having mild, moderate, or severe behavior problems (see reference #7).

Research findings have sometimes resulted in substantial changes in service delivery. For example, in a longitudinal study on referrals to C.B.S. residential programs, it was shown that over the years, an increasing number of referrals were coming from the northern regions and a decreasing number from the Edmonton region (see reference #8). This finding suggested that preventive services (eg: outreach and relief) in the Edmonton region, more available than in the northern regions, reduced the need for specialized residential programs. Thus, our 5-year plan, as discussed in the next section of this report, calls for the elimination of our specialized residences.

As another example of useful evaluative research, we recently surveyed the

parents of children who made use of the relief spaces at C.B.S. and compared their situations with parents who did not use relief (see reference #9). The results indicated that families which tend to use relief are larger, make greater use of professional support services, and have children with more severe handicaps and more serious behavior problems. Based on this information, a strategy has been established for priorizing relief requests based on these characteristics of the family.

C.B.S. has always been cognizant of providing a quality service with an emphasis on fiscal restraint. Over the last four years, the budget has been reduced by more than a half million dollars and staff decreased by 10 positions through internal adjustments. The Children's Residential Program has progressed from a 6-bed unit to two 3-bed units, to one 3-bed unit. A contracted operator model was implemented to provide a more normalized environment in these intensive units. Several outreach positions have been transferred to the northern regions to reduce residential referrals from these areas. In all cases, management decisions to modify programs have been based on evaluative information.

C.B.S. was instrumental in encouraging local school boards to serve children with mental handicaps and behavior problems. In 1976, children in residence at C.B.S. attended a "school" program offered by C.B.S. staff in the basement of our Administration Building. In 1977, a teacher was contracted from the Edmonton Public School Board to provide the academic training in this space while C.B.S. Counsellors assisted with conduct

problems. In 1978, the Edmonton Public School Board was encouraged to provide a classroom at a local elementary school for children from the C.B.S. residence. In 1979, School Board aides were requested to replace the C.B.S. Counsellors. By 1981, the School Board had assumed total responsibility for the C.B.S. classroom. Within a few years, C.B.S. residents were attending other, more age-appropriate, classrooms in the school system.

In summary, in ten years of service, there have been several major program evaluations, regular consumer and staff evaluations, and numerous research studies conducted at C.B.S. In all cases, the intent of these activities was to improve the effectiveness and efficiency of services provided by C.B.S.

# WHERE ARE THEY NOW

As stated earlier, C.B.S. has served over 1,400 individuals in the past 10 years. But what becomes of them after we "close their files"? Do they continue to progress? Do their parents continue to use the skills they learned from us? Do the individuals remain with their families? Is the "success" maintained for an extended period of time?

To answer these questions, a sample of 90 individuals was drawn at random from our Outreach files.** A survey form was designed and data collected both from the files and a telephone call or home-based interview with each of the families we were able to contact (n=67).

Information was gathered on whether families had received home consultation or had attended the parent workshops, if our involvement had been successful (i.e., the behaviors reached an agreed-upon criterion), if parents were still using the skills they had learned, and if their sons or daughters who had had behavior problems were still living with them. The skills taught to parents included formal behavioral programming, including data collection, contingency management, program evaluation, etc. Thisinformation was taught with the focus on "catching their child being good" (praising appropriate behavior and ignoring inappropriate behavior). Other information provided to parents included the use of

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** A similiar survey being conducted with individuals who particpated in the Residential Program was not completed at the time of this report.

natural and logical consequences and behavioral contracting.

Of the 67 families who completed the survey, 8% received home consultation and 92% attended the parent workshops. C.B.S. was successful in changing the inappropriate behavior of the children in 88% of these families. Although only 13% indicated that they still conduct formal programs, the majority of parents (92%) reported that they continue to praise their children for appropriate behavior and ignore inappropriate behavior. Most of the children (88%) were still with their families; the remainder (12%) had moved from the family home to other settings (foster homes and group homes).

Although these findings are from a small sample, they do suggest that C.B.S. is meeting the needs of most families with children who have mental handicaps and behavior problems. It seems likely that many more of these children would have been placed outside of their homes, in foster care, group homes, and institutions, were it not for C.B.S. intervention. While it is encouraging to know we are successful at helping families, the data does raise an interesting question. How simplified could the workshop become given that only 13% of the participants continue to do formal programming? Could the workshop content simply focus on teaching parents to consistently praise and ignore their children's behavior? A comprehensive analysis of this question is being planned for the near future.

# THE FUTURE

The next five years (1986-1991) will see some innovative and dramatic changes occurring in the services provided by C.B.S. A major emphasis will be to reduce the need for specialized facilities for individuals with behavior problems by moving toward preventive interventions. Whenever possible, families and agencies will be supported in dealing with individuals with maladaptive behaviors rather than moving those individuals to specialized facilities.

Of course, our experience at C.B.S. indicates that there will always be a small but highly-visible number of individuals displaying severe maladaptive behaviors which reduce their chances of making a successful community adjustment. For those persons, highly-structured management programs within a facility-based environment is required. What we are proposing here is that such individuals not be congregated in a specialized facility for this purpose, but be disbursed among the existing residential services in the Edmonton region and moved to less restrictive settings as their behaviors improve.

Trends and Impact Factors

A number of plans and situations have been identified which will have an impact on the services:

1. Approximately 450 institutionalized residents, some with severe behavior problems, will be relocated from Michener Centre to the Edmonton region. Although the time-line is unclear, it has been determined that 44 individuals will be relocated in 1986 and 1987. Six of these persons are presumed to have behavior problems although the severity is yet to be determined. The Maladaptive Behavior Scale, developed at C.B.S., will be administered in 1986 to more accurately assess the service needs of these individuals.

2. The Northeast and Northwest regional 5-year plans for behavioral services include both residential and expanded outreach services. These services, which are expected to be developed in 1986, should reduce the need for dependency on specialized residential services in the Edmonton region.

3. A recent survey showed that 149 adults living in the Edmonton community, are currently on waiting lists for existing residential placement. On the other hand, short-term behavioral facilities require "flow" through the system to prevent overservicing. This information highlights a perennial problem of attempting to provide short-term accommodation in specialized facilities (ie., the accommodation becomes "long-term").

4. Parents are keeping their children at home longer versus placing

them outside the home. This attitude shift is partly due to the increase in outreach and relief supports to parents as well as the change in philosophy of professionals regarding institutionalization. The impact on planning is to ensure that such parents continue to receive the necessary support, thus reducing the need for specialized residential facilities.

5. Many schools and agencies in the Edmonton region have increased their efforts to maintain individuals with behavior problems. Such efforts are to be encouraged through staff training and consultation provided either internally or by a regional behavioral service.

Required Services

Changes to C.B.S. programs are proposed to ensure quality behavioral services will continue to be provided to individuals in the Edmonton region. Although all changes relate to modifications of exisitng programs at Community Behavioral Services, there are implications of these changes for other services.

1. Restrict behavioral services to the Edmonton region

As indicated previously, C.B.S. has been providing specialized residential accommodation for individuals from the Northeast and Northwest regions of the Province. This situation has raised a

number of concerns: lack of parental involvement due to distance, lack of post-placement follow-up, and increased cost of service. In 1986, both northern regions will increase their outreach capacity and develop specialized residential services, thus eliminating the need for referral to the Edmonton region. Beginning in April, 1987, behavioral services will not be provided outside of the Edmonton region.

2. Close the Adult Assessment Unit

Since November, 1981, the Adult Assessment Unit has provided assessment and training programs to 22 mentally handicapped adults with mild to moderate behavior problems. The waiting list averaged three or four persons at any given time. As with the childrens' units, lack of post-placement has been a major obstacle in providing intervention on a short-term basis and facilitating an individual's prompt return to a more permanent community residence. Training and follow-up has been difficult for out-of-region referrals because of distance and for Edmonton region agencies who could not "spare" staff from their regular duties to receive on-site training.

The three residents currently in the Adult Assessment Unit are ready for discharge with no post-placements available. One individual has lived at the Unit for almost three years. Due to the length of existing waiting lists, individualized funding

models have been proposed to facilitate the discharge of these persons to more appropriate community settings and prevent further "overservicing" to them.

Many persons referred to the Adult Assessment Unit are unable to be served in existing agencies for one of two reasons; lack of available space or insufficient staffing support given the level of behavior problem the individual is exhibiting. In the latter case, individuals may be referred for specialized residential accommodation or discharged because of insufficient staffing support and no access to the Adult Assessment Unit. By bringing the behavioral supports to the agency, the movement of individuals to a specialized facility is unnecessary.

The five existing staff at the Adult Assessment Unit will provide intensive on-site behavioral support to agency staff in conjunction with outreach consultation for staff training until the behavior problems are at a level the agency staff can handle. The Unit staff will work as an intensive support worker team from their office at the current Adult Assessment Unit site. They will be available to provide "around the clock" support for individuals exhibiting severe behavior problems or work with a number of individuals exhibiting mild or moderate problems. Consultation and follow-up to parents or agencies would be provided by C.B.S. outreach staff.

In order for this plan to be implemented successfully, a number of existing private agencies will be expected to provide one emergency behavioral space to accommodate adults who require temporary placement outside of their parent's home or room-and-board situation.

It should be noted that the elimination of the Adult Assessment Unit will be done on a pilot basis and be evaluated at the end of two years to determine the feasibility of such a plan.

3. Close the Children's Residence

For the last 10 years, C.B.S. has provided four or five "permanent" beds and one or two relief beds for children. On average, the waiting list for admission was no more than five or six children at any given time. During this period, the majority of referrals (75%) were from the northern regions. With the elimination of these referrals by 1987, the number of "permanent" beds can be reduced from three to zero. This plan, of course, requires some changes to the existing continuum of residential services for children since there will always be occasions when a child must be accommodated outside of the home for specialized behavioral instruction.

It is suggested that each agency providing residential services to children reserve one space to accommodate children with

behavior problems who previously would have been referred to C.B.S. These placements would be a last resort and only used if outreach supports were unable to maintain the family unit. The five staff at the C.B.S. children's residence would serve as "Intensive Support Workers" to assist the agency staff with behavioral programs and "hands-on" support. C.B.S. outreach staff would provide parent and staff instruction and consultation in behavioral skills as required.

Again, it is proposed that the elimination of the C.B.S. children's residence be done on a pilot basis and be evaluated at the end of two years to determine the feasibility of such a plan. The facility, in the interim, would be used as a home-base for the team of Intensive Support Workers.

4. Initiate a children's relief/instructional model

The elimination of the C.B.S. children's residence cannot occur until: (1) referrals from the northern regions terminate and (2) behavioral spaces are designated within existing group homes. Until that time, the C.B.S. residence will use their three beds to provide relief for a maximum of 12 weeks. This arrangement will increase parent's expectations that their child will be returning home (ensuring post-placement) and will also encourage parents to be more involved in the instructional programs. Of course, parent instruction and children's behavior-change programs will be implemented as required during this 12-week relief period.

5. Develop relief options which do not utilize a specialized residence

Assuming that the children's residence is phased out, then the relief space would also be eliminated. In 1986, a 3-bed relief facility will be available to children with mild to moderate behavior problems. This facility will be operated under contract and continue until the relief/instructional model demonstrates its capability to provide adequate relief services to children in the Edmonton region or until it is demonstrated that the relief facility is not being utilized to the extent anticipated. In either case, alternate relief models (eg., professional relief in private homes) will be developed to ensure that parents have access to relief spaces outside of their homes.

6. Reduce outreach services to large school jurisdictions

A number of teachers currently receive behavioral consultation from C.B.S. outreach staff. This consultation has been provided to ensure consistency of programming between home and school. In the last few years, the larger school jurisdictions, such as the Edmonton Public School Board, have developed behavioral support teams to consult internally to their teachers; thus, consistency of programming between home and school can be maintained through regular meetings of the consultants within the two systems.

To encourage this move toward internal consultation, C.B.S. will

gradually reduce their direct consultation to teachers in certain school jurisdictions (those with expertise in this area). To ensure that school systems can prepare for this reduction of support, a year's notice will be given to the identified school boards. Beginning with the Edmonton Public School Board, it is recommended that C.B.S. discontinue consultation after school year 86-87. This change will allow C.B.S. to reallocate its outreach staff in new areas of service delivery described in the following five objectives (7-11).

7. Increase outreach services to "at risk" children

We know from the literature that early intervention with behavior problems is beneficial and that without such intervention, early behavior problems are a significant predictor of maladjustment during the teen and adult years. We also know that child abuse/neglect and Child Welfare involvement is a complex problem involving child behavior problems, lack of parenting skills, marital discord, insularity, etc., etc. Over the years C.B.S. has turned down numerous requests for intervention with preschool children who display behavior problems but are not mentally handicapped; most likely some of these children will eventually require Child Welfare intervention although regional data is not available to verify this hypothesis.

It is proposed that C.B.S. outreach services conduct a pilot

project with a limited number of such referrals (30 in 1986), providing parent instruction and family counselling as required. Outcome measures would include pre- and post-tests of behavioral knowledge and parents attitudes toward their child, behavior changes in the child and parent-satisfaction data. Follow-up longitudinal data with a matched group of parents who did not receive C.B.S. services would assess the effectiveness of the intervention in terms of subsequent Child Welfare involvement with the family.

8. Increase outreach services to native Indians

The native population is assuming greater responsibility for delivering its own social services. At the present time, C.B.S. is discussing with native groups the possibility of offering parent instruction and consultation to families of children who have mental handicaps and behavior problems. In the event that the native population develops their own similar services, C.B.S. would offer advice, information, and staff training as requested.

9. Increase outreach services to Child Welfare referrals

A number of families are involved with Child Welfare who have a child with behavior problems but without a mental handicap. C.B.S. is involved in a pilot project of providing services to these families in the form of parent instruction, consultation, and counselling as required. If outcome measures are positive

and caseloads are not excessive, C.B.S. will propose an expanded mandate to serve this population with similar rationales for serving the "at risk" group.

10. Increase intensive outreach consultation to families and agencies

The benefits of providing more than the typical weekly consultation to parents of children whose behavior is not improving as expected was documented in 1985 through a pilot project with outreach staff. Hands-on demonstration and immediate on-site feedback proved effective in teaching behavioral techniques; thus, this service will be increased and include agencies as well.

11. Provide behavioral in-services to agencies

From 1976 to 1980, C.B.S. provided in-services in behavioral instruction to agencies serving people with mental handicaps. In June of 1980 this activity was terminated because of conflicting mandates with a local community college (Grant MacEwan) which was also providing behavioral courses intended for private-agency staff. Unfortunately, because of cost and time restrictions, agencies did not participate in these college courses to the extent anticipated. In the ensuing 5 year period (1980-1985), it became increasingly apparent that agency staff require specialized training in order to design and implement behavioral programs which will be maximumly beneficial to the individuals

they serve. Thus, these in-services will again be offered to agencies by C.B.S. beginning in 1986. The College will continue to offer specialized behavioral courses for agencies upon request.

12. Increase support to high-functioning individuals

A number of adolescents and young adults have been identified who are functioning at the "borderline" level (IQ 70-85) and would benefit from life-skills instruction and counselling. Beginning in 1985, the C.B.S. Social Services Team has conducted bi-weekly group meetings for eight of these youngsters, ages 12 - 20. The success of this pilot project will be evaluated in the fall of 1986 and decisions made as to whether to continue this group and also whether to expand the age range or offer separate groups for other ages.

13. Revise mandate of C.B.S. to include research and program evaluation

Over the last 10 years, C.B.S. has shown initiatives in conducting research in the areas of behavioral instruction and developmental disabilities resulting in a number of publications in local and international journals (see Reference Section of this report). At the present time, research activities have a low profile at C.B.S. and most are conducted by the Director and Program Managers. This is unfortunate in view of the innovative

programs that are being carried out and the unique coordination mechanisms and staff expertise that make C.B.S. a model program.

A second area of concern is the unavailability of staff in the Edmonton region to conduct program evaluations, both individual and agency, with the intent of improving service delivery. Over the years, professionals from outside the Province have had to be hired to conduct these evaluations at various agencies. This lack of local expertise is both costly and inefficient in terms of maintaining liaison with an agency as they address recommendations from the evaluation.

In 1986, consideration will be given to expanding the mandate of C.B.S. to include a focus on research and program evaluation. A half-time staff person at the Psychologist II level will be hired to conduct these activities and to train C.B.S. staff in research philosophy and methodology. The expected outcome is for C.B.S. to continue to improve its programs, and, with increased publications, serve as a model for other behavioral-support programs throughout the world. This research psychologist would, of course, also be involved in evaluating the effectiveness of changes implemented at C.B.S. over the next five years.

14. <u>Transfer C.B.S. from government to community operation</u>

Consistent with the Department's initiatives to encourage

increased community responsibility for rehabilitation programs, C.B.S. submitted a "notice of intent" in 1985 to divest itself from government and operate under a non-profit community board. Assuming this notice is approved, a detailed proposal to transfer by April, 1987 will be developed for Departmental review. Since all of the above 5-year objectives relate to the programs at C.B.S., the transfer to board status will not hamper their implementation.

Assuming the transfer occurs in 1987, C.B.S. as a community agency would then be eligible to propose and operate similar services within other regions of the Province as well as the Edmonton region. This expansion is intended to facilitate the coordination of behavioral services within and across these regions.

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## C.B.S. Staff between 1975 and 1985 (*current staff)

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